

11234 CERTIFICATE OF DEATH

11227

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Chas.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heisterville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlotte Hall,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>CLARK</u> First <u>JAMES</u> Middle <u>BRAGG</u> Last <u>CLARK</u>		DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1890</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>	IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jackson Bragg</u>		14. MOTHER'S MAIDEN NAME <u>Emeline Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>101-10-10101</u>	
17. INFORMANT <u>Walter C. Cabell</u>		Address <u>Heisterville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>1945</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-12-58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dr. Bragg's residence</u>	20f. (City or town) (County) (State) <u>Chas. Md.</u>
21. I certify that I attended the deceased from <u>10-15-58</u> and that death occurred at <u>2:15</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.		DATE SIGNED <u>10-12-58</u>	
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>		ADDRESS <u>La Plata Md</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT.</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Weldorf, Md</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

11234 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

AGE 100

100-100-100

DEATH

Charles H. O.

100-100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235 CERTIFICATE OF DEATH

11228

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				d. STREET ADDRESS <u>Nanjemo</u>			
3. NAME OF DECEASED (Type or print) First <u>LAZARUS</u> Middle <u>Peter</u> Last <u>DODD</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Powder Factory</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Dodd</u>				14. MOTHER'S MAIDEN NAME <u>Emma Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT Address <u>Mrs. Mary F. Dodd, Nanjemoy, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> , 1958, to <u>10-28</u> , 1958, that I last saw the deceased alive on <u>10-26</u> , 1958, and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, State) <u>La Plata, Md.</u> DATE SIGNED <u>10-28-58</u>			
PHYSICIAN'S NAME (Type) <u>F.M. JOHNSON</u>				same -			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanjemo Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Nanjemo, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt & Funeral Home, Waldorf, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the general director, page 2 by the registrar. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11335

March

HEALTH BOARD

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		65		M		W		1878		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY	
RETIRED		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		NATURAL		MARCH 10, 1943		BALTIMORE		MD	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
MARCH 10, 1943		BALTIMORE		MD		USA		USA		MARCH 10, 1943		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
MARCH 10, 1943		BALTIMORE		MD		USA		USA		MARCH 10, 1943		BALTIMORE		MD		USA	

11236 CERTIFICATE OF DEATH

11229

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>M.D.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
c. LENGTH OF STAY IN 1b <u>1 hr 25 min</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>La Plata Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lori</u> First <u>Virginia</u> Middle <u>Intervale</u> Last		4. DATE OF DEATH <u>10-4-58</u> Month <u>10</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-58</u>
9. AGE (In years lost birthday) yrs. <u>25</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u> Hours <u>25</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brooke A. Entwistle</u>		14. MOTHER'S MAIDEN NAME <u>Olive V. Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rev. Herbert Costain, Indian Head, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral - Pulmonary</u> <u>762.0</u> DUE TO <u>Asphyxia - General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 25 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-4-58</u> , 19 <u>58</u> , to <u>10-4-58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>10-4-58</u> , 19 <u>58</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James Henderson</u> M.D.		ADDRESS (Street, city or town, state) <u>Indian Head Md</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		DATE SIGNED <u>10-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Pomonkey Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>OCT 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066304XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11230

Reg. Dist. No.

<p style="font-size: 1.2em; margin: 0;">11237</p>		<p style="font-size: 1.2em; margin: 0;">11230</p>	
<p>1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u></p>	
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Bel Alton</u></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>		<p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>ROGER</u> First <u>FRANCIS</u> Middle <u>GARNER</u> Last</p>		<p>4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>17</u> Year <u>1958</u></p>	
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>3-31-13</u></p>	
<p>9. AGE (In years last birthday) <u>45</u> yrs.</p>		<p>10. IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Md</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Richard W. Garner</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Elizabeth Welch</u></p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> W.W. <u>11</u></p>		<p>16. SOCIAL SECURITY NO. <u>213-16-2821</u></p>	
<p>17. INFORMANT <u>Bessie Welch</u> Address <u>Bel Alton</u></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 422.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.1 Chronic Alcoholism</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>NONE</u></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occurred while walking up a steep hill.</u></p>	
<p>20c. TIME OF INJURY Month, Day, Year <u>5:30</u> <u>10-17</u> <u>1958</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u></p>		<p>20f. (City or town) <u>Bel Alton</u> (County) <u>Charles</u> (State) <u>Md.</u></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</p>			
<p>ACTUAL SIGNATURE <u>V. B. Dettor</u></p>		<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>EXAMINER'S NAME (Type) <u>V. B. DETTOR</u></p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>DET.</u> MEDICAL EXAMINER <input checked="" type="checkbox"/></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>10/21/1958</u></p>	
<p>22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u></p>		<p>22d. LOCATION (City, town, or county) <u>La Plata, Maryland</u> (State)</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u> ADDRESS <u>La Plata, Maryland</u></p>		<p>24a. REC'D BY REGISTRAR <u>OCT 22 '58</u></p>	
<p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u></p>		<p>DATE SIGNED <u>10-18-58</u></p>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial—cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM O. HAGENS</u>		4. DATE OF DEATH Month Day Year <u>10 - 10 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 4 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Warren Hagens, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to smoke</u> 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>and 50% second degree thermal burns</u> DUE TO (b) <u>10min</u> (c) <u>10min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidental fire in a closed room</u>	
20c. TIME OF INJURY Hour <u>2:30</u> a.m. Month, Day, Year <u>10-10-1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Waldorf</u> (County) <u>Charles</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V.B. Detton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-10-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf Md.</u>		24a. REC'D BY REGISTRAR <u>10-14-58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>	
DATE OF DEATH <i>1955</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St, Baltimore, MD</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		IMMEDIATE CAUSE <i>Coronary Thrombosis</i>	
PREVIOUS ILLNESS <i>None</i>		PREVIOUS INJURY <i>None</i>		POST-MORTEM EXAMINATION <i>Not performed</i>	
SIGNATURE OF EXAMINER <i>[Signature]</i>		DATE <i>1955</i>		PLACE <i>Baltimore, MD</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11239

CERTIFICATE OF DEATH

11232

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles, Waldorf</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Waldorf</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Elaine</u> Last <u>Hawcock</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1932</u>	9. AGE (In years last birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Goldsmith</u>				14. MOTHER'S MAIDEN NAME <u>Lorraine Middleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>George L. Hawcock, Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized spread of malignant cell</u> <u>202.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Lymphoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-26</u> , 19 <u>57</u> , to <u>10-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-10</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Dobson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>10-11-58</u>			
PHYSICIAN'S NAME (Type) <u>Richard N. Dobson M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	

CERTIFICATE OF DEATH

11588

1. NAME OF DECEASED <i>John William Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>May 15, 1928</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jane Smith</i>		12. SIGNATURE OF REGISTRAR <i>Wm. H. Brown</i>	
13. PLACE OF BIRTH <i>Baltimore, Md.</i>		14. DATE OF BIRTH <i>May 1, 1863</i>		15. OCCUPATION <i>Teacher</i>	
16. MARITAL STATUS <i>Married</i>		17. NAME OF SPOUSE <i>Elizabeth Smith</i>		18. EDUCATION <i>High School</i>	
19. RELIGION <i>Methodist</i>		20. COLOR <i>White</i>		21. HEIGHT <i>5' 8"</i>	
22. WEIGHT <i>160 lbs.</i>		23. BUILD <i>Slender</i>		24. HAIR <i>Gray</i>	
25. EYES <i>Blue</i>		26. SKIN <i>Fair</i>		27. TENDRILS <i>None</i>	
28. TOOTH <i>None</i>		29. NAILS <i>Short</i>		30. FINGERS <i>Normal</i>	
31. PALM <i>Normal</i>		32. SOLES <i>Normal</i>		33. HEELS <i>Normal</i>	
34. ANKLES <i>Normal</i>		35. KNEES <i>Normal</i>		36. ELBOWS <i>Normal</i>	
37. SHOULDERS <i>Normal</i>		38. NECK <i>Normal</i>		39. THROAT <i>Normal</i>	
40. CHEST <i>Normal</i>		41. BACK <i>Normal</i>		42. LIMBS <i>Normal</i>	
43. HEAD <i>Normal</i>		44. FACE <i>Normal</i>		45. EARS <i>Normal</i>	
46. NOSE <i>Normal</i>		47. MOUTH <i>Normal</i>		48. TONGUE <i>Normal</i>	
49. PHARYNX <i>Normal</i>		50. LARYNX <i>Normal</i>		51. TRACHEA <i>Normal</i>	
52. BRONCHI <i>Normal</i>		53. LUNGS <i>Normal</i>		54. HEART <i>Normal</i>	
55. LIVER <i>Normal</i>		56. SPLEEN <i>Normal</i>		57. PANCREAS <i>Normal</i>	
58. STOMACH <i>Normal</i>		59. SMALL INTESTINE <i>Normal</i>		60. LARGE INTESTINE <i>Normal</i>	
61. RECTUM <i>Normal</i>		62. UTERUS <i>Normal</i>		63. VAGINA <i>Normal</i>	
64. TESTES <i>Normal</i>		65. PROSTATE <i>Normal</i>		66. BLADDER <i>Normal</i>	
67. URETERS <i>Normal</i>		68. PYLORUS <i>Normal</i>		69. DUODENUM <i>Normal</i>	
70. JEJUNUM <i>Normal</i>		71. ILEUM <i>Normal</i>		72. CAECUM <i>Normal</i>	
73. APPENDIX <i>Normal</i>		74. SIGMOID <i>Normal</i>		75. RECTUM <i>Normal</i>	
76. ANUS <i>Normal</i>		77. PERINEUM <i>Normal</i>		78. SCROTUM <i>Normal</i>	
79. PENIS <i>Normal</i>		80. CLITORIS <i>Normal</i>		81. LABIA <i>Normal</i>	
82. VAGINA <i>Normal</i>		83. UTERUS <i>Normal</i>		84. OVARY <i>Normal</i>	
85. TUBES <i>Normal</i>		86. FALLOPIAN <i>Normal</i>		87. VAGINA <i>Normal</i>	
88. CLITORIS <i>Normal</i>		89. LABIA <i>Normal</i>		90. VAGINA <i>Normal</i>	
91. UTERUS <i>Normal</i>		92. OVARY <i>Normal</i>		93. TUBES <i>Normal</i>	
94. FALLOPIAN <i>Normal</i>		95. VAGINA <i>Normal</i>		96. CLITORIS <i>Normal</i>	
97. LABIA <i>Normal</i>		98. VAGINA <i>Normal</i>		99. CLITORIS <i>Normal</i>	
100. LABIA <i>Normal</i>		101. VAGINA <i>Normal</i>		102. CLITORIS <i>Normal</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11240

CERTIFICATE OF DEATH

11233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Winifred D. Lowe		4. DATE OF DEATH Month Oct Day 30 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1919
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY doctors office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A Dyson		14. MOTHER'S MAIDEN NAME Mirian Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-05-0239	
17. INFORMANT J. Douglas Lowe, White Plains, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLISM 465x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POSTOPERATIVE SUBTOTAL GASTRIC RESECTION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1957 , to Oct 30, 1958 , that I last saw the deceased alive on Oct 30, 19 58 , and that death occurred at 2:30 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. PARRAN JARBOE M.D.		ADDRESS (Street, city or town, state) La Plata, Md.	
PHYSICIAN'S NAME (Type) J. PARRAN JARBOE M.D.		DATE SIGNED 10-30-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 68</p>		<p>4. DATE OF BIRTH 1900</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Retired</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 1925</p>	
<p>9. NAME OF SPOUSE Mary H. Harris</p>		<p>10. DATE OF DEATH 1975</p>	
<p>11. PLACE OF DEATH Baltimore, Md.</p>		<p>12. CAUSE OF DEATH Heart Disease</p>	
<p>13. MEDICAL HISTORY Hypertension, Atherosclerosis</p>		<p>14. PRESENT ILLNESS Anginal pain, 1 week</p>	
<p>15. PHYSICIAN'S SIGNATURE J. H. Harris</p>		<p>16. COUNTY CLERK'S SIGNATURE J. H. Harris</p>	
<p>17. DATE OF CERTIFICATE 1975</p>		<p>18. COUNTY Baltimore</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11241

Reg. Dist. No.

11234

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural/Tompkinsville/COBB ISLAND c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COBB ISLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tompkinsville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE BENJAMIN MOORE First Middle Last 4. DATE OF DEATH OCTOBER 17 1958 Month Day Year		5. SEX MALE 6. COLOR OR RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Aug. 2, 1908 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Charles Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard F. Moore		14. MOTHER'S MAIDEN NAME Elizabeth Roye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mrs. Carry Thomas (Sister) Address Tompkinsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0 Probable acute alcoholism 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ship while working	
20c. TIME OF INJURY Month, Day, Year 4:30 P.M. 10-17 1958		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or Not while <input type="checkbox"/> at work RIVER	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cobb Island, Charles, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V.B. Detto		DATE SIGNED 10/18/58	
EXAMINER'S NAME (Type) V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1958	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		22d. LOCATION (City, town, or county) (State) Issue, Charles Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc., La Plata, Maryland		24a. REC'D BY REGISTRAR OCT 22 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11242

CERTIFICATE OF DEATH

11235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STEPHAN</u> First Middle <u>NALBORCZYK</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-03</u>
9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGR.</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>POLAND.</u>	
13. FATHER'S NAME <u>Johann Nalborczyk</u>		14. MOTHER'S MAIDEN NAME <u>KAROLINA KUBIK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-620</u>	
17. INFORMANT Address <u>Maria Nalborczyk Port Tobacco</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse</u> DUE TO <u>540.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive hemorrhage from upper G.I.</u> DUE TO <u>36 hrs.</u> (c) <u>Gastric ulcer</u> DUE TO <u>6 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1955</u> , to <u>Oct 23, 1958</u> , that I last saw the deceased alive on <u>23 October, 1958</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woodydy</u> M.D.		ADDRESS (Street, city or town, state) <u>LaPlata, Md.</u> DATE SIGNED <u>23 Oct 58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODYDY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery Chapel Point, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arhart Funeral Home, Inc. LaPlata, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11515

11515

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES BOND		M		45		JAN 15 1900		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JAN 20 1945		10:30 AM		10:30 AM		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF REGISTRATION		HOUR OF REGISTRATION		TIME OF REGISTRATION		TEMPERATURE		PULSE	
JAN 20 1945		10:30 AM		10:30 AM		98.6		60	

11243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Virginia Last NORRIS		4. DATE OF DEATH Month OCTOBER Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE US-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1873
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Norris		14. MOTHER'S MAIDEN NAME Mary V. Farrall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Robert Nalley (Niece)		Address La Plata, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Coronary artery atherosclerosis, Congestive failure		INTERVAL BETWEEN ONSET AND DEATH 3 mi. 5 yrs. 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Re had CVA in Sept 1951.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 1951, to 2 Oct , 1958, that I last saw the deceased alive on 2 Oct , 1958, and that death occurred at 11:58 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Wooddy M.D.		DATE SIGNED 20 Oct 58	
PHYSICIAN'S NAME (Type) ARTHUR WOODDY, M.D.		ADDRESS La Plata, Md.	
22a. BURIAL, CREMATION, ETC. (Specify) BURIAL		22b. DATE THEREOF Oct, 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Newport, Charles Co., Md.	
23. FUNERAL HOME'S SIGNATURE AREHART FUNERAL HOME, INC. LA PLATA, MD.		24a. REC'D BY REGISTRAR OCT 7 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1234

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		White		12/15/1920		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Date of death		15. Place of death		16. Duration of illness		17. Name of attending physician		18. Name of hospital		19. Name of funeral home		20. Name of cemetery	
Teacher		High School		Married		12/20/1920		Baltimore, Md.		3 weeks		Dr. J. Smith		St. Mary's Hospital		Doe & Sons		Greenwood Cemetery	
21. Name of informant		22. Relationship to deceased		23. Date of completion		24. Registrar's name		25. Registrar's title		26. Registrar's address		27. Registrar's phone		28. Registrar's fax		29. Registrar's email		30. Registrar's website	
Jane Doe		Wife		12/20/1920		John Doe		Registrar		123 Main St.		555-1234		555-5678		john.doe@state.md.gov		www.state.md.gov	

11244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Md.		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle ROBEY Last ROBEY		4. DATE OF DEATH Month Oct Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27/58
9. AGE (In years last birthday) yrs. 8		10. IF UNDER 1 YEAR Months Days Hours Min. 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME William Mason Robey		14. MOTHER'S MAIDEN NAME Dolly Betty Robey Boswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Contracted pelvis at birth			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-27 , 19 58 , to 10-27 , 19 58 , that I last saw the deceased alive on 19 , and that death occurred at 10:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. M. Johnson		DATE SIGNED 10-27-58	
PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.		ADDRESS (Street, city or town, state) La Plata, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 28 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Solomons Md
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home		ADDRESS Waldorf, Md	
24a. REC'D BY REGISTRAR OCT 29 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11234

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

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11245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road, MARSHALL HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road, MARSHALL HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>A.</u> Last <u>Waterman</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steven G. Dixon</u>		14. MOTHER'S MAIDEN NAME <u>MARY AGNES ROBINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Miss Margaret Hoover</u>		Address <u>Bryans Rd. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>431X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>58</u> , to <u>Oct 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 4</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10-6-58</u>			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.		PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L. MEM. PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VIRGINIA</u>	
23. ALTERNATE REGISTRAR SIGNATURE <u>Raymond A. Giska</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11525

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1925</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1945</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. DATE OF DEATH <i>Dec 10 1970</i>		14. TIME OF DEATH <i>10:00 AM</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
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45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
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51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
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97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	



1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF MARRIAGE
9. NAME OF SPOUSE
10. PLACE OF MARRIAGE
11. CAUSE OF DEATH
12. PLACE OF DEATH
13. DATE OF DEATH
14. TIME OF DEATH
15. SIGNATURE OF PHYSICIAN
16. SIGNATURE OF REGISTRAR
17. SIGNATURE OF WITNESS
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians' Memorial Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Winters Last Winters				4. DATE OF DEATH Month 10 Day 13 Year 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 13 Hours 15 Min.		IF UNDER 24 HRS. Months 69 Days 13 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stanly Edelen				14. MOTHER'S MAIDEN NAME Louise Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218 38 8450		17. INFORMANT McKinley A. Winters, La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 1957 INTERVAL BETWEEN ONSET AND DEATH 48 Hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1957 , 19 10-13 , 19 58 , that I last saw the deceased alive on 10-13 , 19 58 , and that death occurred on 10-13 , 19 58 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 10-17-'58							
ACTUAL SIGNATURE E. J. Edelen M.D.				DATE SIGNED 10-17-'58			
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-58		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold F. Ford				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE OCT 20 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Farris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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